State of Missouri

Department of Mental Health

A Plan for Achieving Multicultural Competency

Introduction

In October, 1998, Roy C. Wilson, M.D., Director of the Department of Mental Health (DMH), convened a statewide committee to draft a cultural competency plan for DMH. The minority groups identified in the original plan were determined through the use of census data and demographic information about Department service usage patterns. Based on this information, four ethnic minority groups were identified. Also, since spoken English is not the primary means of communication for a significant portion of the individuals in some of these ethnic minority groups, the committee decided to include linguistic competency as a issue to be addressed in the plan. Through the analysis of service usage patterns; the Deaf and Hard of Hearing population emerged as a significant culture presenting similar communication and linguistic competency issues. Based on this information the five minority groups addressed in the original plan included: African Americans, Asian/Pacific Islanders, Deaf and Hard of Hearing, Latinos, and Native Americans. As a result of discussions about other groups, the committee reached consensus that this plan would be developed as a model that could easily be applied to any cultural group.

In preparing a draft plan, the statewide committee analyzed DMH operational data, surveyed DMH provider agencies, conducted focus groups with individuals from the five minority populations, and reviewed professional literature regarding multicultural competence. A draft plan was submitted to the Department Director in February, 2000.

In 2001, David Satcher, M.D., Surgeon General of the United States, issued a report entitled Mental Health: Culture, Race, and Ethnicity. This report served as a supplement to the landmark Surgeon General's Report on Mental Health published in 1999 which detailed the best scientific evidence on the nature of mental illness and the most effective treatment approaches. The report on Mental Health: Culture, Race, and Ethnicity documents the nature and extent of disparities in mental health care for racial and ethnic minorities and the promising directions for elimination of these disparities. This report provides the best information available regarding the mental health status and access to quality mental health care for four of the five minority groups addressed in the draft plan prepared by the cultural competency committee convened by Dr. Wilson: African Americans, Hispanic Americans, Native Americans, and Asian Americans and Pacific Islanders.

In October, 2002, Dorn Schuffman, Director of the Department of Mental Health, convened a task force to update and revise the draft plan submitted to Dr. Wilson, based on the findings of the Surgeon General's report on Mental Health: Culture, Race, and Ethnicity. The task force consisted of Department staff, many of whom had participated in the committee originally established by Dr. Wilson. This document is the result of the work of that task force. Because the task force only involved DMH staff, this document is only a draft. It requires review and, perhaps, revision by DMH consumers, customers, and providers, and especially by individuals and organizations that represent the minority populations it is intended to address, before it is adopted as the Cultural Competence Plan of the Department of Mental Health.

This document follows the Surgeon General's report on Mental Health: Culture, Race, and Ethnicity in defining the following key terms:

Race: The Report notes that "race" is not a biological category: "No consistent racial groupings emerge when people are sorted by physical and biological characteristics." (pg. 7) Instead, "race" is better understood as a social category: "The concept of race is especially potent when certain groups are separated, treated as inferior or superior, and given differential access to power and other valued resources." (pg. 9)

Ethnicity: "Ethnicity refers to a common heritage shared by a particular group," where 'common heritage' includes shared or similar "history, language, rituals, and preferences for music and foods." (pg. 9)

Culture: The Report also references the concept of 'common heritage' in defining 'culture' as a "common heritage or set of beliefs, norms, and values," but notes that individuals who identify themselves as part of the same racial or ethnic groups may "identify with other social groups to which they feel a stronger cultural tie such as being Catholic, Texan, teenaged, or gay."

Minority: The term 'minority' is used in the Report to signify a group's "limited political power and social resources, as well as [its] unequal access to opportunities, social rewards, and social status. The term is not meant to connote inferiority or to indicate small demographic size." (pg. 5)

In general, the term "minority group" or "minority population" will be used in this document to refer to any racial, ethnic, or cultural group that has "limited political power and social resources, as well as unequal access to opportunities, social rewards, and social status", regardless of demographic size.

Vision, Values, Principals and Goals

The Department of Mental Health vision and values provide the context for all of the work of the Department, including efforts to fulfill our responsibility to meet the specialized needs of minority populations. Three of the nine DMH values are particularly relevant to these efforts:

> **Cultural Diversity: "**All people are valued for, and receive services that reflect and respect, their race, culture, and ethnicity."
>
> **Competence:** "All people receive services delivered by staff who are competent in dealing with cultural, race, age, lifestyles, gender, sexual orientation Religious practice, and ethnicity.
>
> **Valued Workers:** "All people who provide services and supports are our organizations' most important resource."

Within the context of the DMH vision and values, the Department has established the following vision, values, principles, and goals that are specific to fulfilling our responsibility to minority populations.

Vision of the Department of Mental Health for Multicultural Competency:

- The Department of Mental Health will help consumers maximize their human potential by valuing, promoting, offering services, and using natural supports that are culturally and linguistically competent.

Values of the Department of Mental Health regarding Multicultural Competency:

- An integrated approach in which Multicultural Competency is inextricably embedded in all levels of the system.
- The celebration of consumer individuality is seen as enriching the entire system.
- Maximizing consumer potential by providing services that recognize, understand, and respond to the consumers' cultural, linguistic and spiritual needs.
- A system that embraces the concepts of recovery and MRDD support processes.
- Consumers will have an environment where universal acceptance, respect and learning are fundamental and indispensable.

Guiding Principles of the Department of Mental Health regarding Multicultural Competency:

- The following five principles formed the basis for guiding the work of the Multicultural Competency Committee

  Principle I Multicultural competence shall be integrated throughout the entire DMH service system in whatever form the system assumes.

  Principle II The Multicultural Competency Plan including action Steps will be consumer focused and driven; therefore, consumer input is essential throughout the process.

  Principle III Individual differences and abilities are considered and valued across a person's life span (from infancy to elderly).

  Principle IV Consumers are able to maximize their human potential when their:
  - culture is understood and recognized;
  - treatment is culturally and linguistically responsive;
  - spirituality and beliefs are considered;
  - hope is encouraged, enhanced, and/or maintained; and
  - individuality is promoted through recovery and MRDD support processes.

  Principle V Multicultural competence should foster an environment that:
  - values acceptance;
  - encourages learning;
  - expects respect;
  - accepts language differences; and
  - promotes education.

Goals of the Department of Mental Health regarding Multicultural Competency:

- Promotion of cultural awareness and development of cultural competency

- Identification and reduction of mental health care disparities among cultural and ethnic minority population

- Mitigation of risk factors and promotion of protective factors for consumers and the various ethnic and cultural groups they represent

- Improvement of ethnic and cultural diversity within the Department's workforce

Missouri Demographics

During the decade from 1990 – 2000, Missouri's population became more diverse. There were large percentage increases in the Hispanic/Latino and Asian/Pacific Islander populations, and the African-American and American Indian/Aleut populations increased by larger percentages than the overall state population. Though the numbers of Hispanic/Latinos, Asian/Pacific Islanders, and American Indian/Aleuts are relatively small, the rates of increase suggest that encounters between the DMH service systems and these populations will increase. An examination and understanding of these increases will assist DMH with planning and deployment of culturally appropriate services and staff.

Chart 1

Changes in State Populations, 1990 – 2000

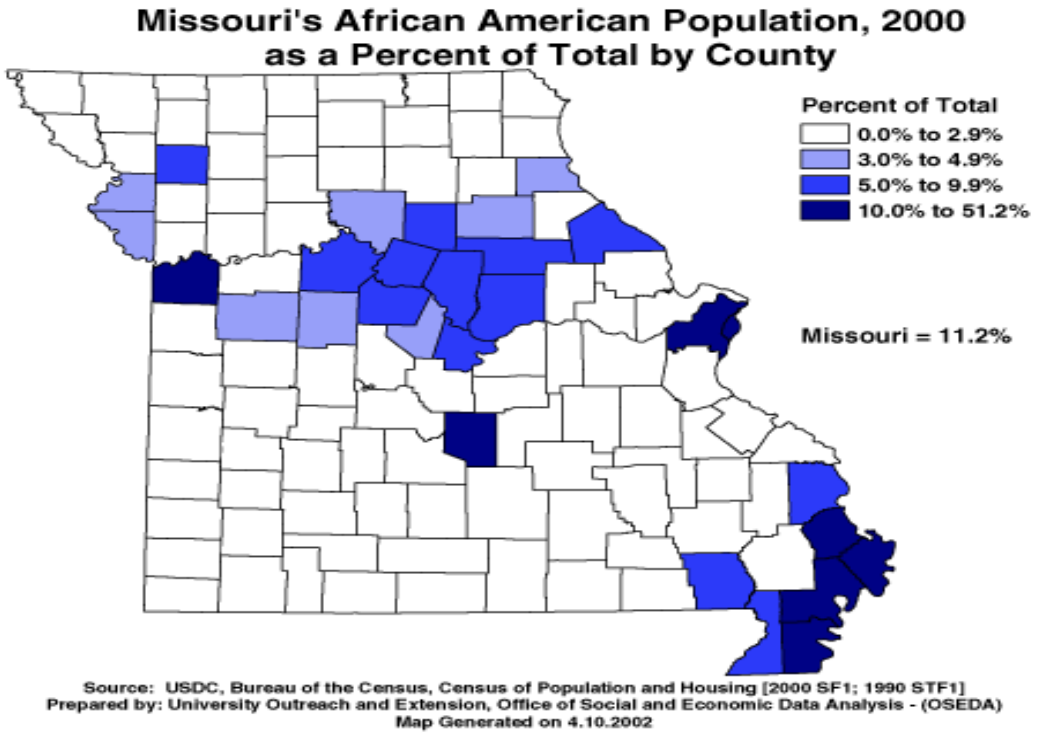
Group	1990 Census	2000 Census	Difference	Percent +/-
African American	548,208	629,391	81,183	+ 14.8%
Hispanic/Latino	61,702	118,592	56,890	+92.2%
Asian/Pacific Island	41,277	64,773	23,496	+56.9%
American Indian/ Aleut	19,835	25,076	5,241	+26.4%
Missouri	5,117,073	5,595,211	478,138	+9.3%

African Americans

African Americans remain Missouri's dominant minority group. Between the 1990 and 2000 census, the African-American population increased by 14.8 percent—from 548,208 to 629,391. This rate of increase, while the lowest of all minority groups, was significantly greater that the 9.3 percent overall increase of Missouri's population. African American's comprise 11.2 percent of the state's population; an increase from 10.7 percent in 1990.

Missouri's African-American population is clustered in 32 counties, which are home to 98 percent of African Americans. Of those counties, there are 8 in which African Americans comprise more than 10 percent of the population: Jackson, Mississippi, New Madrid, Pemiscot, Pulaski, St. Louis City, St. Louis County, and Scott. Essentially, African Americans are heavily clustered in the Kansas City and St. Louis metropolitan areas and the Bootheel. (Pulaski County, in the south central region of the state, is home to a military base, Fort Leonard Wood.) 21 of the remaining 24 counties stretch across the middle of the state, roughly following the course of the Missouri River. Counties in this area include Pike, Audrain, Boone, Callaway, Cole, Howard, and Cooper. (Though largely thought of as an urban population, African American's are present in significant numbers in some mainly rural and semi-rural counties — e.g., Howard, Cooper, Pike, Randolph, Pemiscot, and New Madrid.) Map 1 displays the density of the African-American population by county.

Map 1



St. Louis City continues to have the most African Americans even though the numbers of African Americans decreased from 188,408 to 178,266. As part of the continuing overall trend of population moving from St. Louis City to St. Louis County, the African-American population of St. Louis County experienced the largest increase of African Americans: 53,988 (38.8 percent). Also, as part of the continuing overall trend of population increases in Kansas City/Jackson County, the African-American population grew from 135,649 in 1990 to 152,391 in 2000. Eighty-seven (87) percent of the increase in Missouri's African-American population occurred in Jackson and St. Louis Counties; their increases totaled 70,730.

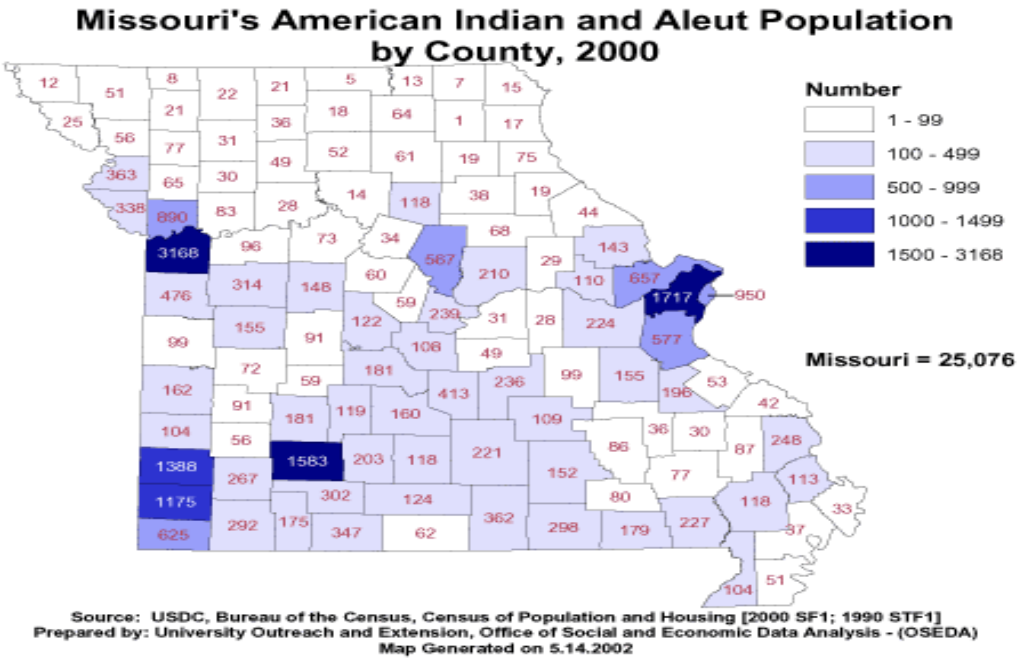
Native Americans

American Indians constitute the smallest group discussed in this section; their population, though, experienced significant growth — from 19,835 to 25,076 (a 26.4 percent increase). American Indians account for 0.4 percent of Missouri's population.

As displayed on Map 2 the American Indian population is dispersed throughout Missouri (all 115 counties have some Indian population), though are large concentrations (population of at least 500) in and around the counties with the state's largest cities: Jefferson, St. Louis City, St. Louis County, St. Charles, Jackson, Clay, Greene, and Boone. Newton, Jasper, and McDonald are the other counties with American Indian populations of at least 500. Jackson County continues to have the largest number of American Indians, 3,168 but their percentage increase, 4.5 percent, was significantly less than the population's overall increase, 26.4 percent, statewide.

Most of the counties having an Indian population of greater than 100, but less than 500 are throughout the Ozarks in southern and southwestern Missouri.

Map 2

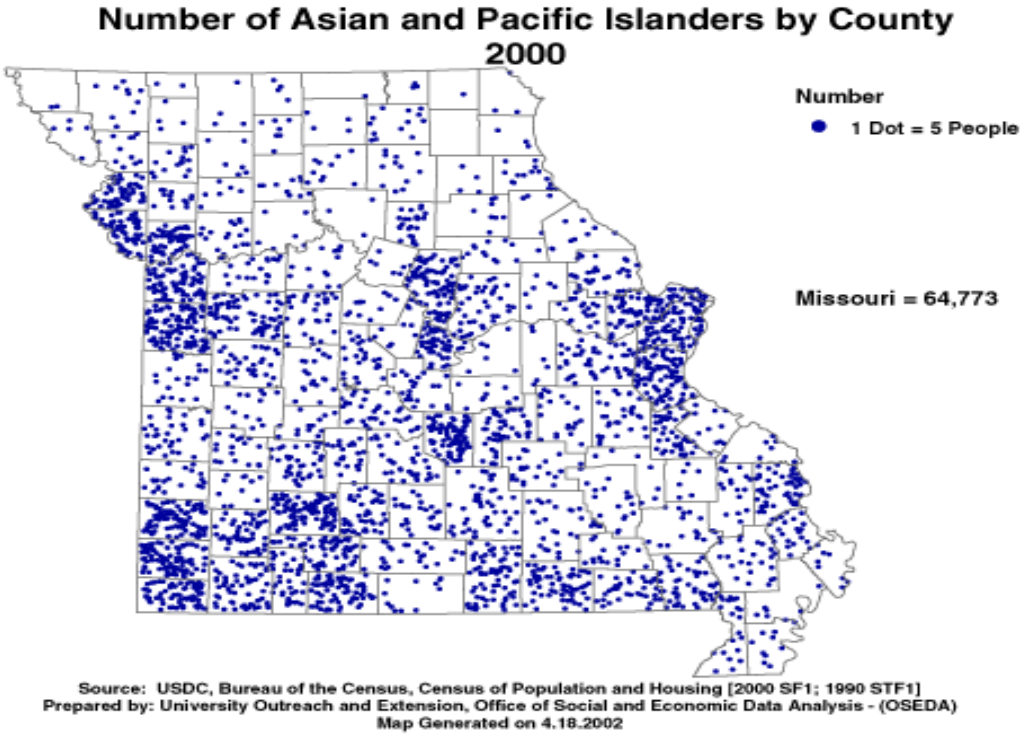


Asian Americans and Pacific Islanders

Missouri's Asian/Pacific Islander population increased 56.9 percent (from 41,277 to 64,773) from 1990 to 2000; 3,071 individuals in this population are Native Hawaiian and other Pacific Islander. The percentage growth of Asian/Pacific Islanders was the second-largest of all populations discussed in this section. Asian/Pacific Islanders now comprise 1.2 percent of Missouri's population—up from 0.8 in 1990.

There is an Asian/Pacific Islander population in all of the state's 115 counties. St. Louis and Jackson Counties have the largest Asian/Pacific Islander populations, 22,857 and 9,580, respectively (see Map 3). Overall, the Asian/Pacific Islander population increased in 99 counties between 1990 and 2000.

Map 3



Though approximately 50 percent of Missouri's Asian/Pacific Islander population lives outside of Jackson and St. Louis Counties, it is a highly urbanized population. The overwhelming majority of the other 50 percent live in the Kansas City, St. Louis, and Columbia SMA—there is also a significant Asian/Pacific Islander population in Pulaski County (Fort Leonard Wood).

The Asian/Pacific Islander population grew fastest in the nine counties with 1,000 or more Asian/Pacific Islander residents. The increase of Asian/Pacific Islander population in these jurisdictions was 64.1 percent from 1990 to 2000. In comparison, the Asian/Pacific Islander population grew by 29.3 percent in the remaining counties of the state.

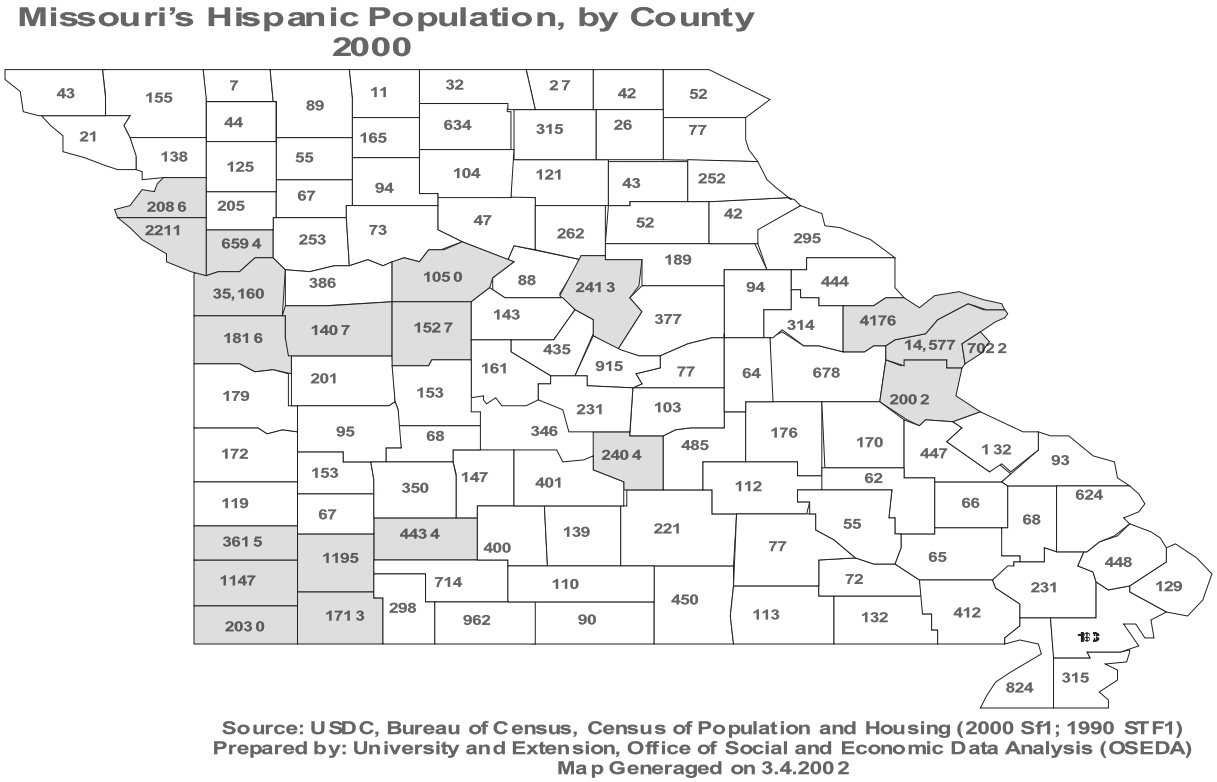
Hispanic Americans

Hispanic Americans are Missouri's fastest growing racial/ethnic population with an increase of 92.2 percent in the past decade. Hispanic Americans are Missouri's second-largest racial/ethnic group, population 118,592, following African Americans. Even so, they account for a relatively small percentage of the state's population—2.2 percent.

Hispanic Americans are found in all of Missouri's counties (see Map 4); and in some counties, e.g., Osage, out-number African Americans. In contrast to the African-American and Asian/Pacific Islander populations, the "clusters" of Hispanic American

population are more widely dispersed across the state. Counties with more than 1,000 Hispanic American residents are found in the eastern part of the state (metropolitan St. Louis), metropolitan Kansas City, along a narrow belt running south of the Missouri River from Boone to the Kansas border, and in the southwestern part of the state. There are relatively few Hispanic Americans in south central Missouri and across the northern tier

Map 4



The metro Hispanic American population increased by 80.1 percent (from 50,399 to 90,785) during the 1990s while the non-metro Hispanic American population increased by 146 percent (from 11,303 in 1990 to 27,807 in 2000 - an increase of 16,504).

There were 20 counties having a 2000 Hispanic population of at least 1,000. Of those 20 counties, 13 are located in one of the metropolitan areas. By far the largest Hispanic American population is in Jackson County, which increased from 18,890 in 1990 to 35,160 - an increase of 86.1 percent. Following Jackson County the next greatest Hispanic populations in 2000 were St. Louis County, 14,577; St. Louis City 7,022; Clay County 6,594; Greene County, 4,434; and St. Charles County, 4,176.

There are ten counties in which the Hispanic American population more than quadrupled (increase of more than 300 percent). These 10 are all counties in which there was a dramatic increase in demand for workers during the 1990s. Taney County (Branson) was one of those counties and illustrates the effect of dramatic employment growth. Employment in Taney County doubled during the 1990s and demand for

workers far exceeded local supply. Hispanics were among workers moving to the county to fill jobs. As a result, the Taney County Hispanic population increased from 194 in 1990 to 962 in 2000 - an increase of almost 400 percent.

In the remaining nine counties, large scale production of poultry or swine was associated with establishment of major meat processing facilities, creating a large demand for packing house workers. Hispanic American workers were recruited both from within and outside the U.S. to meet local demands. Consequently, there were dramatic increases in Hispanic population in those counties, especially during the last half of the 1990s. Five of those counties are in Missouri's Southwest corner and are focused on poultry production and processing. Illustrative of the impact, the Hispanic population increased from 1990 to 2000 in those counties as follows: Barry County, from 152 to 1,713; McDonald County, from 121 to 2,030; Lawrence County, from 211 to 1,195; Newton County, from 353 to 1,147; and Jasper County, from 797 to 3,615. Similar industrial, and therefore demographic, changes occurred in Dunklin County in the Bootheel (Hispanic population growth from 169 in 1990 to 824 in 2000) and in Pettis and Moniteau Counties in central Missouri. The Hispanic American population increased from 268 to 1,527 in Pettis County and from 46 to 435 in Moniteau County.

Two additional counties, Saline and Sullivan, experienced similar additions of major meat processing plants and subsequent Hispanic American immigration to meet demand for labor. In Saline County the Hispanic American population increased from 208 to 1,050 and in Sullivan County, the Hispanic America population increased from 28 to 634.

In aggregate the 10 counties in which the Hispanic American population more than quadrupled during the 1990s had a Hispanic population of 2,279 in 1990 and 13,605 in 2000. These 10 counties accounted for 3.7 percent of Missouri's Hispanic population in 1990 but 11.5 percent in 2000.

Deaf and Hard of Hearing

There is a recognized culture of deaf and hard of hearing persons that cuts across other variables such as race, ethnicity, and socioeconomic status. It is not highly visible to the general public but exists nonetheless. Rather than taking a pathological view of this population, the Department adheres to the cultural view, which defines the deaf and hard of hearing community as a group of people that shares a common means of communication (sign language) that provides the basis for group cohesion and identity, and whose primary means of relating to the world is visual.

On a national level, there is evidence of clinical biases toward deaf and hard of hearing people that result in longer inpatient admission stays with less treatment provided than would be expected in the hearing population (Dickert, 1988). In addition, deaf and hard of hearing consumers often report limitations in receiving services, such as inaccessibility to service and poor quality of service (Pollard, 1994).

Using data compiled by the 2000 Census, we can estimate that Missouri has nearly a half million citizens that are deaf or hard of hearing. Public testimony and focus groups resulted in the deaf community expressing negative feelings toward both the lack of services as well as their adequacy for the deaf and hard of hearing population.

Although the Department currently collects little reliable information about deaf and hard of hearing consumers, the situation that is being resolved by the addition of several required items to its case register system. The Committee recognized that the collection of data on deafness and hearing loss is crucial and must be accomplished throughout the public mental health system.

Summary

Though Missouri's non-African-American minority populations are small, census data indicate that significant growth is occurring. Significantly, this growth is not confined to the major metropolitan areas of the state. These data suggest that the department consider cultural issues and needs across all facilities (state-operated or contracted) in all areas of the state. Similarly, as noted in the introduction to this document, as Missouri's population continues to change, there may be other minority groups that require specialized attention either locally, or on a statewide basis. The Department of Mental Health has an obligation to monitor population changes, and to expand and update its cultural competence initiatives in order to best advocate for and meet the mental health needs of Missourians.

Cultural Competence

Competence is defined as having sufficient knowledge, judgment, or skill to perform a service or function. In the provision of mental health services, a distinction can be made between general and specific or specialized competence.

General competence can be defined as having the:

- Awareness of, and sensitivity to, specialized needs
- Knowledge and skill to identify the presence of specialized needs, and
- Knowledge and relationships necessary to make appropriate referrals for specialized services.

Specific or specialized competence can be defined as having the:

- Knowledge and skill to conduct a comprehensive assessment of specialized needs, and
- Knowledge and skill to serve individuals with specialized needs.

Applying this distinction to meeting the needs of cultural minorities, the Department of Mental Health is committed to:

Goal #1: Cultural Competence

Assure that DMH facilities and providers exhibit **general competence** in serving individuals regardless of race, ethnicity, or culture; and that DMH facilities and providers that are responsible for serving a significant percentage of minority individuals exhibit **specific competence** to meet the specialized needs of those individuals.

In order to achieve this goal, the DMH Cultural Competence Committee will supervise the development and implementation of standards for documenting and/or certifying the general competence of DMH facilities and programs for serving individuals regardless of race, ethnicity, or culture. These standards are likely to include requirements that DMH facilities and programs

- assess their awareness of, and sensitivity to, the specialized needs of minorities;
- provide training to staff regarding specialized cultural needs, based on the assessment;
- use screening methods and tools that assure the identification of specialized needs; and
- maintain referral relationships to assure access to specialized services when appropriate.

The Cultural Competence Committee will also establish expectations regarding DMH facilities and programs that should develop specialized competence to serve specific minority populations, as well as develop guidelines to assist those facilities and providers in developing the necessary specialized competence.

It must be acknowledged that acquiring and maintaining general competence in serving individuals regardless of race, ethnicity, or culture is an ongoing developmental process in which there is always room for growth and improvement. This is true because of continuing changes in the demographics of the populations served, the programs and staff providing services, and our understanding of cultures and how best to meet diverse needs.

Finally, it must also be acknowledge that we face an even greater challenge in achieving the goal of assuring that appropriate facilities and programs exhibit specialized competence in meeting these needs of specific minority populations. This is true, not only because of the changes in demographics, programs and staffing, and our understanding of cultures noted above, but because the depth of our knowledge regarding what “works best” in meeting the specialized needs of specific cultures remains extremely limited. The need for certain types of specialized expertise, such as the ability to speak the same language, is obvious. However, a great deal remains to be learned about how best to engage and appropriately support individuals in a way that both respects and affirms their cultural heritage and takes advantage of cultural strengths, while avoiding approaches or techniques that frustrate, or even create barriers to effective services and supports.

Prevention

A comprehensive approach to multi-cultural competency for the Department of Mental Health (DMH) involves more than addressing the skills and abilities necessary to provide culturally competent services. It should also address culturally specific risk and protective factors aimed at the prevention of disorder development.

Approach

The Department of Mental Health's strategic approach to prevention is based on a model developed by the Institute of Medicine [*reference*]. This model defines three prevention strategies based on population: universal, selective, indicated.

Universal strategies are those that address a population without regard to risk for or presence of a disorder. Examples include public education about the dangers of drinking and driving. These activities are directed to the universe of a population, including, in this example, non-drinkers and those who don't drive.

Selective strategies are those that address a population that may be at elevated risk for disorder development. Continuing with the drinking and driving example, selective prevention activities would be directed toward the population of people who drink and who drive—this being the population at elevated risk for driving after drinking.

Indicated strategies are those that address the population that has begun to exhibit aspect of the problem. In the case of our example, prevention activities would be directed toward the population of people who have driven after drinking, including those who have not experienced arrest.

This approach allows for tailoring prevention and intervention activities differently for each segment of the population.

Risk and Protective Factors

In the area of physical health, the concept of risk factors is well established—e.g., with smoking and lung cancer. Within mental health, the concept of risk factors has become established over the past 20 years largely through the work of Hawkins and Catalano [*reference*] and others [*reference*]. Their research has firmly established the existence of factors in the individual-peer, community/environment, family, and school domains that place individuals at elevated risk for development of behavioral disorders.

Risk Factors are those aspects of the individual, family, school, and community/environment that place individuals and groups~~,~~ at elevated risk for disorder development (for example, teenagers who drink are at greater risk for attempting suicide than teens who don't drink). It is important to note that risk factors are associated with disorder development but are not predictive.

Protective Factors are those aspects of the individual, family, school, and community/environment that protect individuals from disorder development (for example, success in school is associated with lower risk of delinquency). Protective factors, like risk factors, are not predictive.

The 2001 Surgeon General's report, Mental Health: Culture, Race, and Ethnicity, included extensive discussion of the role culture may play in the etiology of mental disorders and in individual and group responses to those disorders once developed. The report states that "culture and social contexts, while not the only determinants, shape the mental health of minorities and alter the types of mental health services they use." Therefore, DMH prevention efforts must involve efforts to mitigate and respond to risk and protective factors that appear related to culture, race, and ethnicity. (It should be noted that mitigation of some of the risk factors cited in the Surgeon General's will

require a multi-faceted approach, involving a broad range of state departments, and a broad, coordinated array of policy approaches.)

There are a number of environmental risk factors that disproportionately effect minority populations, including poverty, homelessness, incarceration, foster care, and exposure to violence or trauma. What are the implications of these risk factors for the provision of culturally competent prevention, intervention, and treatment?

Research findings indicate that, for example, among the major mental illnesses, there is wider variation in the prevalence of major depression than for schizophrenia and bipolar disorder. The research also indicates a stronger association between environmental factors and major depression than appears to exist between environmental factors and schizophrenia and bipolar disorder. Specifically, poverty and exposure to violence appear to be risk factors for major depression. Therefore, multi-cultural competence would seem to require the development of skills and resources to address the role violence and poverty play in disorder development.

Though the department cannot, on its own, mitigate the risks posed by poverty and violence, it can mitigate the impact these risk factors have on individuals and groups. Through a focus on protective factors in, especially, the individual-peer, school, family, and community/environment domains, the department can mitigate the risks posed by poverty and violence. For example, supportive families and good sibling relationships can protect against the onset of mental illness. Therefore, by identifying individual, family, school, and community/environment protective factors, the department can work toward mitigating those risk factors that may influence disorder development and care seeking by minority groups.

“Migration, a stressful life event, can influence mental health. Often called acculturative stress, it occurs during the process of adapting to a new culture.”

Missouri has experienced significant growth in the number of immigrants over the past decade. From 1990 to 2000 Asian/Pacific Islander population increased by 57 percent and the Latino/Hispanic population increased by nearly 100 percent. Though both populations are a small percentage of the state’s population, 1.2 and 2.2 percent, respectively, their growth suggest that the department consider the role that immigration plays in the development of mental disorders. While immigration *per se* is not a risk factor for disorder development, the stresses attendant to migration and the fact that many immigrants have experienced trauma from war, civil unrest, or forced relocation prior to migration suggest that these populations may experience problems requiring response from the department.

Due to the timing of Asian/Pacific Islander migration to Missouri, this population is a generation removed from the traumas of the conflicts in Southeast Asia (the Vietnam War and the genocide in Cambodia) and the Cultural Revolution in China. They, as a group, though, maintain a family structure that is both risk and protective. Protective in that they maintain large, relatively cohesive and organized family structures, and risk in that mental health problems are highly stigmatized within the family group. Culturally competent mental health services would, therefore, seek to address the risk factor of stigma, which presents a barrier to seeking services.

Latino/Hispanic populations are, on average, of low socio-economic status and have relatively low educational status. They are, therefore, subject to some of the risk resulting from these factors. Research indicates that Mexican Americans born in the

United States have higher rates of depression and phobias than those born in Mexico. Other studies have concluded that Latino/Hispanic children experience a significant number of mental health problems, "and in most cases, more problems than whites."

For Asian/Pacific Islander and Latino/Hispanic populations (as with all other cultures) it will be necessary and important to discern patterns of care seeking and to better understand symptom formation. Also, especially for Latino/Hispanic populations, it will be important to ensure the availability of Spanish-speakers throughout the treatment process.

Given this diversity of cultural risk and protective factors, the Department of Mental Health is committed to:

Goal #2: Prevention

Promote culturally specific protective factors that foster good mental health, and reduce culturally specific risk factors that increase the likelihood of the development of mental health problems.

In order to achieve this goal, the Department will need to take action on two fronts.

First, the Department will assure that DMH universal, selective, and indicated prevention activities include initiatives targeted to each of the minority populations identified in this plan, based on what is known about the risk and protective factors specific to those minority groups.

Second, as the state mental health authority, DMH will work with other social service agencies and advocates to educate policy makers and the public regarding the disproportionate correlation between minority populations and high risk factors such as poverty, homelessness, incarceration, foster care, and exposure to violence or trauma.

Minorities and Mental Health Care Disparities

The Surgeon General's report on Mental Health: Culture, Race, and Ethnicity demonstrates that minority groups have disparate access to, and utilization of, mental health services and supports, as well as disparate mental health outcomes. To a large extent this is because minority populations are over-represented among people living in poverty, as well as among other high risk groups, including individuals who are homeless, incarcerated, in foster care, and exposed to violence or trauma.

As the public mental health authority, the Department of Mental Health serves as the safety net for mental health care, serving individuals regardless of the ability to pay. Consequently, individuals who are poor are more likely to access DMH services than those with an ability to pay. As a result, largely because minority groups are over-represented in among people living in poverty, minority groups are also over-

represented among the individuals receiving services from the Department of Mental Health.

In FY 2002, the Department provided services to 176,899 individuals, of whom 45,248 were from minority groups as defined in this plan. Therefore, although minority groups account for only about 14% of Missouri's population, more than is 25%, or one in four, of the consumers served by the Department in FY 2002 were from a minority group.

DIVISION	WHITE	BLACK	OTHER
ADA	71.3%	25.4%	3.3%
CPS	76.9%	19.9%	3.1%
MRDD	73.6%	18.4%	7.9%

Nevertheless, access to care remains problematic for certain minorities, and in specific geographic areas. In general, Hispanic American individuals are under-represented, and in urban areas, where African Americans account for a larger percentage of the population (St. Louis: 51%; Jackson County: 23%), African Americans may be under-represented.

The Surgeon General's report also suggests that many persons from minority groups receive services in the primary care setting or from the faith community. This is an area that requires further study by the Department in order to effectively impact the quality of care and outcomes of persons receiving treatment in these settings.

There are also disparities in the utilization of DMH services and supports by minorities. Preliminary analysis suggests that minority groups receive services, supports and treatments in more restrictive settings, and are more like to use emergency services, terminate services more quickly, and be forced into treatment through the criminal justice system or civil commitment.

The Department of Mental Health has annually surveyed consumers and family members regarding satisfaction with DMH services and supports since 1998. The survey is an important measure of consumer and family perception of the process and quality of service provision. (The Department does not consider the satisfaction survey to be a measure of service outcomes.)[1] Differences in satisfaction among various consumer demographic groups are analyzed for statistical significance. Analysis of the 2001 Satisfaction Survey shows:[2]

- All groups were generally satisfied with services provided by the Department. There are, however, differences between demographic groups.
  - Females were more satisfied with services than males.
  - Whites and Native Americans had the highest satisfaction with services of any racial/ethnic group.

[1] The survey asks people to rate their level of satisfaction with a variety of aspects of services. Satisfaction Reports are posted on the DMH web site at http://www.modmh.state.mo.us/pm2001/index.htm

[2] The survey uses a 5 point Likert scale: 1 = not at all satisfied, 5 = very satisfied.

  - Although the ratings of both African Americans and Hispanics were in the satisfied range, their ratings tended to be lower than those of Whites.
  - The youngest consumers (up to 18 years old) were the least satisfied with services.
- All groups gave a satisfied rating to staff for respect for culture, with exception of the Pacific Islander group.[3]

Appendix B provides a table of survey questions that had statistically significant differences between groups of different racial and ethnic backgrounds.

In addition to disparities in access, utilization, and consumer satisfaction, additional analysis of outcome data is needed to determine whether there are also disparities among minority populations in terms of consumer outcomes in Missouri.

The Department of Mental Health is committed to:

Goal #3: Minority Mental Health Care Disparities

Reduce mental health care disparities among minority populations.

In order to achieve this goal, the DMH Cultural Competence Committee will develop and monitor minority specific data regarding disparities in access to, utilization of, satisfaction with, and outcomes of mental health services and supports. The specific data to be developed and monitored will, at least, include information regarding:

- Percent of clients served by Division
- Hospitalization
  - Percent of admissions
  - Inpatient days
  - Length of Stay
  - Percent of readmissions within 30 days
  - Percent on new atypical medications
  - Percent of restraints
  - Percent of seclusions
- Commitments
  - Percent of Civil Involuntary Commitments
  - Percent of Forensic Commitments
- Percent enrolled in specific programs by service area
  - CPRC
  - Targeted Case Management
  - CSTAR
  - Family Directed Services
  - ICF-MR Waiver
- Percent of consumers showing improvement in outcomes
- Consumer Satisfaction

[3] Only eight respondents identified themselves as Pacific Islanders—a sample too small to support any far-reaching conclusions.

Based on a review of this data, the DMH Cultural Competence Committee will identify factors that may be contributing to any apparent disparities, and recommend strategies for reducing mitigating the factors and reducing the disparities.

Cultural Diversity in the Workplace

The Department of Mental Health strives to maintain a workforce that is highly qualified and competent, while reflecting the diversity of the citizens we serve. A diverse workforce strengthens the Department's ability to provide culturally sensitive services to individuals of all races, ethnic heritage and cultures, regardless of gender. To that end, the Department has developed an Affirmative Action Plan. Affirmative Action is the adoption of culturally conscious hiring practices to achieve a work force that reflects the population of the communities we serve. The goals set forth in the Department's Affirmative Action Plan are designed to promote continued improvement in the development and maintenance of a well qualified, competent, and appropriately diverse work force.

Three major challenges face the Department of Mental Health in assessing the extent to which the Department's workforce appropriately reflects the diversity of the general workforce in Missouri.

First, workforce data from the 2000 Census has not yet been released by the federal government. Therefore, despite significant changes in Missouri's workforce in recent years, we are forced to rely on data from the 1990 Census. Once data is available from the 2000 Census, we will update our analyses and plans accordingly. In the meantime, we can only note major trends in workforce that are likely to be reflected in the 2000 Census data. Two trends are of

- A significant reduction in the population of St. Louis City and a significant growth in southwest Missouri.

- A significant growth in the number of individuals of Hispanic background in certain parts of Missouri.

The reduction in the population of St. Louis and growth of the population in southwest Missouri also illustrates the second challenge that faces the Department in analyzing workforce data: the importance of looking at data on a regional basis. The Missouri Office of Administration divides the state in to a number of Labor Manpower Areas (LMA(s) for the purposes of analyzing workforce data. This is extremely important for the Department of Mental Health because the majority of its workforce is located in facilities around the state that primarily recruit staff from their adjacent communities. Consequently, assessing the Department's success in reflecting the diversity of Missouri's workforce is dependent upon assessing the diversity of the available workforce in the appropriate LMA(s). We know, for example, that although African Americans account for 11.2% of the Missouri population, some areas of the state where DMH facilities are located have a much higher percentage of African Americans, notably St. Louis City (51.2%) and Jackson County (23.3%). It would not be

appropriate to measure the diversity of the facilities located in these areas against statewide data.

The growth in Missouri's Hispanic population illustrates the third challenge that faces the Department in analyzing workforce data: All minorities, except African Americans, are grouped together and reported as "other minorities" in the available workforce data. Therefore, although we know that some parts of the state now have a significant Hispanic population (e.g. Jackson County at 5.4%), we have no way to determine the actual size of the available Hispanic workforce, or any other minority group, except African Americans, by EEO category or Merit System classification.

Taken together, these challenges suggest caution in drawing broad conclusions from the available data. An accurate understanding of the Department's progress in assuring appropriate diversity of its workforce is dependent on careful analysis at the LMA level, and will require significant reassessment once data is available from the 2000 Census.

Because the majority of the Department's employees are located in its facilities, it is critical that each facility have an effective Affirmative Action Plan and Affirmative Action processes that accurately analyze the current status of the facility workforce compared to the available workforce in the appropriate LMA(s), set forth realistic goals and strategies for improvement, and establish mechanisms and responsible parties for implementing the strategies and measuring progress.

Because the majority of the individuals served by the Department receive their services through contract providers, the Department also has a responsibility to promote the development of a culturally diverse workforce among our contract providers.

The Department of Mental Health of Mental Health is committed to:

Goal #4: Cultural Diversity

> Improve the diversity of the DMH workforce as outlined in the DMH Affirmative Action Plan.

The DMH Affirmative Action Plan outlines the Department's specific objectives and strategies for achieving this goal.

Action Plan

As noted in the introduction, this document is a draft plan that requires review by DMH consumers, customers, and providers, and especially by individuals and organizations representing the minority populations on which it focuses. In order to initiate the review process, and to create a mechanism that can consider comments, make appropriate revisions, and then oversee implementation of the plan, the Department is establishing a DMH Cultural Competence Committee. The DMH staff that developed this draft document will serve on the Committee along with consumer and provider representatives from each of the three divisions of the Department, and representatives from the CPS and MR/DD facilities. Derrick Willis, Coordinator of the Office for Multi-Cultural Affairs will chair the Committee. The Committee will provide

quarterly progress reports to the DMH Executive Committee, and will revise and update the action plan annually. The Department Director will report progress to the Mental Health Commission quarterly.

Goal #1: Cultural Competence

Assure that DMH facilities and providers exhibit **general competence** in serving individuals regardless of race, ethnicity, or culture; and that facilities and providers that are likely to have a significant percentage of minority individuals with specialized needs exhibit **specialized competence** to meet those needs.

General Competence

Objective #1

Document each DMH facility's general competence to serve individuals regardless of race, ethnicity, or culture by July, 2005.

Objective #2

Certify each DMH provider's general competence to serve individuals regardless of race, ethnicity, or culture by July, 2006.

Specialized Competence

Objective #3

Determine which DMH facilities and providers should be expected to develop specialized competence for specific minority populations by January, 2004.

Objective #4

Establish processes for the development of guidelines to assist DMH facilities and providers in developing specialized competence for specific minority populations by March, 2004.

Goal #2: Prevention

Promote culturally specific protective factors that foster good mental health, and reduce culturally specific risk factors that increase the development of mental health problems.

Objective #1

Assure that DMH prevention activities include initiatives targeted to each of the minority populations identified in this plan by July, 2004.

Objective #2

Work with other social service agencies and advocates on an ongoing basis to educate policy makers and the public regarding the disproportionate correlation between minority populations and the following high risk factors: poverty, homelessness, incarceration, foster care, and exposure to violence or trauma.

Goal #3: Minority Mental Health Care Disparities

Reduce mental health care disparities among minority populations.

Objective #1

Develop and monitor minority specific data regarding disparities in access to, and utilization of, DMH services, including, at least, any disparities in program enrollments and facility admissions; lengths of stay; commitments; restraints and seclusion; abuse and neglect; consumer satisfaction; and outcomes by March, 2004 and on an ongoing basis.

Objective #2

Identify factors that may be contributing to disparities in access and utilization, and develop strategies for reducing the disparities by October, 2004.

Goal #4: Cultural Diversity

Improve the diversity of the DMH workforce in accordance with the Affirmative Action Plan.

Objective #1

Develop an Affirmative Action Plan for Central Office by April 15, 2003.

Objective #2

Develop an Affirmative Action Plan at each DMH facility by July, 2003.

Objective #3

Promote the development of a culturally diverse workforce among DMH contract provider.

APPENDIX A

FIGURE 1: FISCAL YEAR 1998 DMH UNDUPLICATED ADMISSIONS

Unique count of clients admitted to DMH facilities or providers, by division, in FY1998. In the last column, a client counts once, even if served by multiple divisions

Race	ADA	CPS	MRDD	Total Clients
Alaskan-Native (Eskimo-Indian)	7	11	2	20
American Indian	284	197	44	280
Asian/Pacific Islander	49	47	57	145
Bi-Racial	95	148	115	328
Black/Non-Hispanic	23,223	13,823	6,082	39,790
Oriental	81	131	78	280
Spanish American	332	337	120	738
White/Non-Hispanic	40,216	54,560	23,770	111,454
Other	221	271	253	700
Unknown	94	548	598	1,157
TOTAL	64,602	70,073	31,119	155,092

Division of ADA		Division of CPS	
Black	35.9%	Black	19.7%
White	62.3%	White	77.9%
Other	1.8%	Other	2.4%
Division of MRDD		All DMH	
Black	19.5%	Black	25.7%
White	76.3%	White	71.9%
Other	4.2%	Other	2.4%

FIGURE 1: FISCAL YEAR 2002 DMH UNDUPLICATED ADMISSIONS

Unique count of clients admitted to DMH facilities or providers, by division, in FY2002. In the last column, a client counts once, even if served by multiple divisions

Race	ADA	CPS	MRDD	Total Clients
Alaskan-Native (Eskimo-Indian)	11	16	4	30
American Indian	338	297	73	631
Asian/Pacific Islander	112	70	99	269
Bi-Racial	159	296	257	649
Black/Non-Hispanic	18,399	15,461	7,591	37,754
Oriental	112	164	135	391
Spanish American	608	592	168	1,281
White/Non-Hispanic	51,528	59,626	30,287	131,165
Other	446	368	428	1,178
Unknown	568	637	2,103	3,065
TOTAL	72,281	77,527	41,145	176,899

Division of ADA		Division of CPS	
Black	25.4%	Black	19.9%
White	71.3%	White	76.9%
Other	3.3%	Other	3.1%
Division of MRDD		All DMH	
Black	18.4%	Black	21.3%
White	73.6%	White	74.4%
Other	7.9%	Other	4.2%

DMH employees by Division by Race (2002)

	AFRICAN AMERICAN	%	WHITE	%	OTHER DIVERSE GROUPS	%	TOTAL
CPS Facilities	1,427	28%	3,562	69%	160	3%	5,149
MR/DD Facilities	1,622	35%	2,974	64%	86	2%	4,682
Central Office	40	9%	391	89%	6	1%	437
Total DMH	3,089	30%	6,927	67%	252	2%	10,268

APPENDIX B

2001 Comparison of Race/Ethnic Background in ADA, CPS, and MRDD Residential and Non-Residential Settings Combined

The analysis compared the responses of consumers by different racial and ethnic backgrounds on the satisfaction survey items. On the average, Caucasians and Hispanics were more satisfied with services than consumers of other racial and ethnic backgrounds. Caucasians were more satisfied with where they lived and how safe they felt in the neighborhood. African Americans were more satisfied with their opportunities to make friends and what they did in their free time.

How satisfied are you…	White	Black	Hispanic	Native American	Pacific Islander	Other	Significance
Services							
With the staff who serve you? (a,b,c)	4.34 (5462)	4.18 (1141)	3.99 (78)	4.28 (107)	4.13 (8)	4.04 (202)	F(5,6992)=11.957, p<.001
With how much your staff know how to get things done? (a)	4.22 (5404)	4.10 (1138)	3.95 (76)	4.22 (106)	4.05 (199)	4.05 (199)	F(5,6925)=6.376, p<.001
With how staff keep things about you and your life confidential? (a,c,d)	4.37 (5363)	4.19 (1134)	4.12 (76)	4.42 (105)	4.00 (8)	4.03 (197)	F(5,6877)=12.021, p<.001
That the treatment plan has what you want in it? (a)	4.19 (5339)	4.07 (1124)	3.83 (76)	4.13 (107)	3.88 (8)	4.02 (197)	F(5,6845)=5.814, p<.001
That the treatment plan is being followed by those who assist you? (a,b,c)	4.24 (5338)	4.11 (1125)	3.88 (78)	4.20 (106)	3.88 (8)	3.98 (196)	F(5,6845)=8.582, p<.001
That the staff respect your cultural background? (a,b,c)	4.39 (5124)	4.22 (1132)	4.00 (73)	4.29 (104)	3.88 (8)	4.15 (193)	F(5,6628)=12.547, p<.001
With the services you receive? (a,c)	4.32 (5389)	4.19 (1132)	4.05 (75)	4.17 (107)	4.13 (8)	4.01 (202)	F(5,6907)=9.458, p<.001
That services are provided in a timely manner? (a,c)	4.22 (5409)	4.04 (1127)	3.92 (76)	4.07 (107)	3.75 (8)	3.94 (197)	F(5,6918)=11.063, p<.001
Quality of Life							
With how you spend your day? (a)	3.53 (5397)	3.69 (1136)	3.61 (77)	3.44 (106)	3.88 (8)	3.46 (191)	F(5,6909)=4.863, p<.001
With where you live?	3.70 (5362)	3.64 (1130)	3.58 (74)	3.42 (107)	3.25 (8)	3.57 (192)	F(5,6867)=2.353, p=.039
With the amount of choices you have? (a,e)	3.46 (5371)	3.64 (1131)	3.59 (76)	3.35 (108)	3.75 (8)	3.31 (192)	F(5,6880)=5.634, p<.001
With the opportunities you have to make friends? (a,e)	3.57 (5342)	3.78 (1127)	3.62 (78)	3.58 (107)	3.63 (8)	3.47 (189)	F(5,6845)=6.761, p<.001
With what you do in your free time?	3.59 (5371)	3.70 (1135)	3.62 (76)	3.32 (106)	4.25 (8)	3.60 (190)	F(5,6880)=3.560, p=.003
With how safe you feel in your neighborhood? (a)	3.91 (5180)	3.75 (1101)	3.89 (70)	3.78 (100)	3.88 (8)	3.67 (181)	F(5,6634)=5.294, p<.001

The first number represents a mean rating.
How satisfied are you? Scale: 1=Not at all satisfied . . . 5=Very satisfied.
How safe do you feel? Scale: 1=Not at all safe . . . 5=Very safe.
The number in parentheses represents the number responding to this item.

Scheffe Post-Hoc significance at .05 or less

(a) Interaction between White and Black.
(b) Interaction between White and Hispanic.
(c) Interaction between White and Other.
(d) Native American and Other.
(e) Black and Other.